SMILES OF CAROLINA
General and Family Dentistry

6807 Knightdale Boulevard, Suite E
Knightdale, NC 27545
Phone: 919/217-4411
Fax: 919/217-4420
info@socdentist.com
www.socdentist.com

Office Hours
Monday through Thursday 7:50am - 5:00pm
Friday 7:50am - 1:00pm

OFFICE POLICIES

- **Broken appointments are costly and inconvenient.** A **TWO business day** notice is required to reschedule appointments or a broken appointment fee may apply. Excessive broken appointments may lead to your dismissal from our practice

- N**on-confirmed appointments** may result in an additional wait time or may need to be rescheduled.

- If you are more than fifteen (15) minutes late to your appointment, we may need to alter treatment to correspond to the remaining appointment time or your appointment may need to be rescheduled.

- Patients under the age of eighteen (18) will not be seen or treated without the presence of a parent or legal guardian. Or a written consent form is provided for another adult family member is authorized to accompany the patient who is a minor. **We require a parent or legal guardian to remain in our office for the duration of the patient's appointment**.

- Deductible, co-pay, coinsurance or any portion not covered by your insurance plan is **due at the time treatment is performed**. We accept Cash, Visa, Mastercard, Discover and Care Credit.

- **Copy of dental records**: there is a $10.00 charge per family, please allow 2 business days for processing.

- **Unpaid balances greater than 90 days** will be sent to a collections agency.

- I understand that insurance is a benefit to me and not the dental office and agree **to be financially responsible for any and all charges not covered by the insurance company** regardless of the reason given by the insurance company for non-payment

- After your dentist has explained your treatment, we will give you a printed treatment plan with the total estimated charges.

- A **deposit of $100** will be collected for all major procedures where appointment lengths are two hours or greater. The deposit of $100 is collected upon scheduling the appointment and is deducted from the total patient portion for treatment. Failure to provide a 2 business day cancellation notice will result in a loss of the $100 deposit.

I, _____ have read the information and fully understand its content.
PRINT Patient or Parent/Guardian

_____ _____
Patient/Guardian signature *Date*

PATIENT PROTECTED HEALTH INFORMATION
AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name	Date of Birth
Smiles of Carolina is authorized to release health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. Indicate each person or entity that you allow us to receive your information & the type of information to be released.	

☐ Voice Mail What detailed information may be left on your voicemail?	☐ Results and/or Xrays ☐ Financial ☐ Treatment & Appointments
☐ Spouse List spouse name & your information that you permit to be disclosed	☐ Results and/or Xrays ☐ Financial ☐ Treatment & Appointments
☐ Parent(s) List names & your information that you permit to be disclosed	☐ Results and/or Xrays ☐ Financial ☐ Treatment & Appointments
☐ Other	☐ Results and/or Xrays ☐ Financial ☐ Treatment & Appointments

I UNDERSTAND:

1. *I have the right to revoke this authorization at anytime and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.*
2. *Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*
3. *I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.* ***This authorization shall be in effect until revoked by the patient.***

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____

Patient/Guardian signature *Date*

SMILES OF CAROLINA
General and Family Dentistry

PATIENT INFORMATION

Today's date:

PATIENT INFORMATION

Patient's Last name	First	Middle	Preferred Name	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.

Date of Birth	Age	Social Security number	Marital status (circle one)	Drivers License	Sex
			Single / Mar / Div / Sep / Wid		❑ M ❑ F

Home address	City	State	ZIP code

Home phone number	Work phone number	Mobile phone number	Email
( )	( )	( )	

Who referred you to our office ❑ Google ❑ Friend/Family ❑ Insurance ❑ Office Sign ❑ Other

RESPONSIBLE PARTY

Person responsible for bill	Date of Birth	Address (if different):	Relationship to patient
	/ /		

Home phone number	Work phone number	Mobile phone number
( )	( )	( )

Home phone number	Work phone number	Mobile phone number	Email
		( )	

INSURANCE INFORMATION

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:
		/ /		

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other — Insurance Tel #

Secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other — Insurance Tel #

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Smiles of Carolina. I understand that I am financially responsible for any balance. I also authorize Smiles of Carolina or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

SMILES OF CAROLINA
General and Family Dentistry

PATIENT CONSENT FORM

Patient name	Date of Birth

The undersigned hereby authorizes: *PLEASE INITIAL NEXT TO EACH PARAGRAPH*

Initials here	The Doctor to perform any and all forms of necessary treatment that may be indicated to include the following: prophylaxis (dental cleaning), restorations (fillings), crowns (caps), fixed bridgework (a series of joined caps), full or partial removable dentures, cosmetic dentistry, routine and surgical extraction (tooth removal), non-surgical and/or surgical treatment of the gums, biopsy, root canal, prescription of medication or any other treatment the dentist considers necessary.
Initials here	The Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs.
Initials here	The use of a **local anesthetic, antibiotics and analgesics** (pain medication): I understand that more than one injection may be necessary to obtain satisfactory or desired results during treatment. The use of local anesthesia embodies a certain risk, although they are considered extremely safe. These risks include allergic reactions (including anaphylactic shock), nausea/vomiting, aspiration, pain (analgesthesis), bruising, discoloration and swelling to soft tissues, injury to blood vessels and nerves. More serious but rare complications include parasthesia or permanent anesthesia (permanent numbness or abnormal sensation, and in very rare instances, life threatening conditions including cardiac arrest. If parasthesia does occur, about 90% of these cases resolve themselves in less than eight weeks. Although rarely needed, a referral to a specialist is pursued for evaluation and treatment if symptoms do not resolve.
Initials here	The Doctor choose and employ such assistance as he deems fit, to include releasing my dental records to any other Doctor to whom I am referred, or to whom the patient may request in writing or verbally by phone or in person
Initials here	I understand It is vital that the person completing these forms give as **accurate and complete a medical and personal history** as possible in which no omissions have been made and to follow any and all instructions as directed.
Initials here	I understand that during treatment, unforeseen conditions may arise which may necessitate procedures different from those discussed prior to treatment. I therefore consent to the performance of any additional treatment which the dentist considers necessary. I understand that there are no assurances or guarantees as to the outcome of the treatment. I realize that in spite of the possible complications, my proposed treatment is necessary and desired by me.
Initials here	Responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time treatment is performed. **Acceptable methods of payment**: Care Credit, Cash, Discover, Mastercard & Visa
Initials here	I understand that insurance is a benefit to me and not the dental office. I agree **to be financially responsible for any and all charges not covered by the insurance company** regardless of the reason given by the insurance company for non-payment

AUTHORIZATION FOR SUBMISSION OF CLAIMS & ASSIGMENT OF BENEFITS

I authorize Smiles of Carolina to submit claims (by mail or electronically) for treatment to the dental care service plans or insurance companies named on the registration form, on my behalf and in my name. I assign to Smiles of Carolina the group insurance benefits entitled to me. **I understand that I am financially responsible for any charges not covered by the insurance plan.** This authorization & assignment of benefits shall be valid for 12 months & one day after my or my family member's last dental visit to this office for treatment.

Patient or Parent/Guardian signature _____ Date _____

I HAVE READ OR HAD READ TO ME AND COMPLETED THE ABOVE WRITTEN MATERIAL AND I ACCEPT FULL RESPONSIBILITY FOR PAYMENT OF ANY ACCOUNT CREATED ON BEHALF OF MYSELF OR THE ABOVE MENTIONED PATIENT. I CONFIRM ALL INFORMATION IS TRUE & I HAVE RECEIVED A COPY OF SMILES OF CAROLINA'S NOTICE OF PRIVACY PRACTICES.

Patient or Parent/Guardian signature _____ Date _____

SMILES OF CAROLINA
General and Family Dentistry

FINANCIAL POLICY ACKNOWLEDGEMENT

The following information is to inform you of our financial policy. If, at any time, you have questions regarding this policy, please do not hesitate to ask any member of our business team. We are committed to providing you with the highest quality care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept, cash, Visa, Mastercard & Discover. We partner with a third-party company, Care Credit to offer deferred interest programs for either 6 or 12 months at 0%.

We communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is expected at the time of treatment. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child or minor to our office for treatment is responsible for payment of all services rendered.

We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment, however, any appointment missed may be subject to a **missed appointment fee of $50**. Should you find it necessary to reschedule an appointment, please provide a two business day notice to avoid being charged a missed appointment fee.

As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion (coinsurances) be paid at the time treatment is performed. We accept "assignment of benefit" as a form to receive payment directly from your insurance carrier, to help reduce your immediate out of pocket expense. We are participating providers with: Aetna PPO II (only), Ameritas/Reliance/Principal, BcBS of NC, Cigna, Connection Dental, Delta Dental PPO, Dentemax, Guardian, Humana, Medicaid/NChealthchoice (children only), Metlife, United Concordia & United Healthcare; however we do not participate with any DMO type plans.

Contact your insurance carrier to obtain essential information which will accurately reflect your coverage. Providing us with this information will expedite the processing of claims. If you have a direct reimbursement policy, payment to us will be made in full and collected on the day of service and your dental plan will reimburse you.

For fillings, we only use composite resin "tooth colored" because they allow a more conservative and esthetic result. **Please be aware that some insurance companies do not cover resins** but cover for a cheaper alternative of amalgam (silver fillings); the patient is responsible for the remaining balance.

After your dentist has explained your treatment, you will receive a printed treatment plan with the total estimated charges. The estimate will show a breakdown of your portion and the insurance coverage. For treatment greater than $250, we will submit a pre-authorization to your insurance carrier so you will be aware of your total out pocket cost & coverage.

IMPORTANT FACTS ABOUT YOUR DENTAL INSURANCE

- Dental insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.
- It is your responsibility to understand the type of dental insurance you have (i.e., traditional, PPO or DMO) and the benefits selected by you and/or your employer.
- You (not the insurance company) are responsible for the fees of services rendered/treatment performed.

_____ _____

Patient or Parent/Guardian Signature Date

Smiles of Carolina

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME	DATE OF BIRTH

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you have, or medication(s) that you take could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Are you under a Physician's care now	☐Yes ☐No	If yes, please explain
Have you ever been hospitalized or had a major operation?	☐Yes ☐No	If yes, please explain
Have you ever had a serious head or neck injury?	☐Yes ☐No	If yes, please explain
Do you take, or have you taken, Phen-Fen or Redux?	☐Yes ☐No	If yes, please explain
Are you on a special diet?	☐Yes ☐No	If yes, please explain
Do you use tobacco products or E-cigarettes "vape"?	☐Yes ☐No	If yes, please explain
Do you use illegal substances?	☐Yes ☐No	If yes, please explain
Do you take any blood thinning medications?	☐Yes ☐No	If yes, please explain
Do you take or have you ever taken bisphosphonate medications(Fosamax, Actonel or Boniva?	☐Yes ☐No	If yes, please explain

LIST ALL medications, vitamins, and supplements that you are currently taking?

WOMEN ONLY								
	Pregnant	☐Yes ☐No	Trying to get pregnant	☐Yes ☐No	Nursing	☐Yes ☐No	Taking oral contraceptive	☐Yes ☐No
	Number of weeks		Name & phone of OB					

Allergies to								
☐ Acryllic	☐ Amoxicillin	☐ Aspirin	☐ Codeine	☐ Hyrdocodone	☐Latex	☐ Metal	☐ Penicillin	☐Local anesthetic, type
☐ Other, please explain:								

AIDS/HIV Positive	☐Yes ☐No	Chemotherapy	☐Yes ☐No	Frequent Headaches	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Alzheimer's disease	☐Yes ☐No	Chest Pain	☐Yes ☐No	Heart Attack	☐Yes ☐No	Leukemia	☐Yes ☐No	Shingles	☐Yes ☐No
Anaphylaxis	☐Yes ☐No	Cold Sores	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Liver Disease	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Anemia	☐Yes ☐No	Congenital Heart Defect	☐Yes ☐No	Heart Pace Maker	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Stomach/Intestinal Disease	☐Yes ☐No
Angina	☐Yes ☐No	Convulsions	☐Yes ☐No	Heart Disease/Failure	☐Yes ☐No	Lung Disease/COPD	☐Yes ☐No	Stroke	☐Yes ☐No
Arthritis/Gout	☐Yes ☐No	Cortisone medicine	☐Yes ☐No	Hemophilia	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Diabetes	☐Yes ☐No	Hepatitis A or B	☐Yes ☐No	Pain in Jaw Joints	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Artificial Joint	☐Yes ☐No	Drug Addition	☐Yes ☐No	Hepatitis C	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Blood Disease	☐Yes ☐No	Epilepsy or seizures	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Radiation Treatment	☐Yes ☐No	Ulcers	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Excessive Bleeding	☐Yes ☐No	Hives or Rash	☐Yes ☐No	Renal Dialysis	☐Yes ☐No	Other (list)	
Bruise Easily	☐Yes ☐No	Emphysema	☐Yes ☐No	HypoHyperglycemia	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No		
Cancer	☐Yes ☐No	Fainting spells/Dizziness	☐Yes ☐No	Irregular Heartbeat	☐Yes ☐No	Rheumatism	☐Yes ☐No		

Explain a serious illness not listed above

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health (or the patient's). It is my responsibility to inform the dental office of any changes in medical status.

Patient or Parent/Guardian Signature	Date

SMILES OF CAROLINA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFOMRATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect August 28, 2009, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to the use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Service: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letter).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $10.00 per family request, $0.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before August 28, 2009. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. Any cost incurred for this purpose will be solely your responsibility.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your compliant with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Mona Mitchell
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Address: 6807 Knightdale Bvld., Suite E, Knightdale, NC 27545